Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: INJURY ONE OF WICHITA FALLS 5931 DESCO DRIVE DALLAS, TX 75225	MFDR Tracking #: M4-10-1733-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: ARCH INSURANCE CO Box #: 19	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Enclosed are copies of the EOB's, claims and supporting documentation. The insurance carrier has denied payment for this claim stating payment is included in the allowance of another service. On this date of service a physical therapy evaluation was completed. Mr. _____ was completing his preauthorized physical therapy sessions and is required to be evaluated by the therapist in accordance with the TX State Physical Therapy Practice Act: Section 322.1. The claim was again denied after reconsideration was completed. Due to this it is now submitted for your review and resolution.

Amount in Dispute: $53.22

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary taken from the Table of Disputed Services: "Provider did not submit modifier 59 – global to G0283."

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
8/4/09	97002-GP	53.68 ÷ 36.0666 x $35.72 = $53.16	$53.22	$53.16
			Total Due:	$53.16

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §133.3 sets out the guidelines for communication between the health care providers and insurance carriers.
3. 28 Tex. Admin. Code §134.203 sets out the medical fee guidelines for professional services rendered on or after March 1, 2008.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 8/18/2009

   - 97 – Payment is incl in the allow for another srvc. The srvcs listed under this procedure code are included in a more comprehensive code which accurately describes the entire procedure(s) performed.

Explanation of benefits 9/18/09

- Reimbursement for procedure was withheld due to a previous submission.

Issues

1. Did the requestor submit billing for services that were included in the allowance of other services?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor billed CPT code 97002. The description of this code is as follows: Physical therapy re-evaluation. The carrier denied the bill with reason code 97 – payment included in the allowance for another service. The EOB denial does not support any other service billed and the requestor did not bill for any other services on the same day. The respondent responded on the DWC-Table of Disputed Services stating "provider did not submit modifier 59 – global to G0283. This rational does not support the EOB denial. The respondent did not submit billing showing HCPCS code G0283 was submitted on the same day to support this rational. Pursuant to rule §133.3 Any communication between the health care provider and insurance carrier related to medical bill processing shall be of sufficient, specific detail to allow the responder to easily identify the information required to resolve the issue or question related to the medical bill. Generic statements that simply state a conclusion such as "insurance carrier improperly reduced the bill" or "health care provider did not document" or other similar phrases with no further description of the factual basis for the sender's position does not satisfy the requirements of this section. The carrier did not fulfill the requirements under rule §133.3. Reimbursement to the requestor for CPT code 97002 is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $53.16.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of $53.16 plus applicable accrued interest per Division rule at 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature	Medical Fee Dispute Resolution Officer	**12/7/10** Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.